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AUTHOR GermAnn, Kathy; Smith, Neale; Littlejohns, Lori Baugh
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ABSTRACT

Efforts of health professionals are shifting away from programs that "deliver health" toward those that build the capacity of communities to work together to create healthy places. The Healthy Communities Initiative (HCI) is a community development model in central Alberta (Canada) that involves the creation of a widely shared vision of a healthier community; assessment of community needs and capacities; selection of priority areas for action; creation and implementation of action plans; and evaluation and monitoring of actions through the development of community-level indicators. Case studies of HCI implementation in four rural communities show that four health-related issues emerged consistently: need for youth development, preservation of the natural environment, maintaining a strong sense of community in the face of changing social dynamics, and access to health services. Capacity-building issues included lack of shard vision, need for further leadership development among both adults and youth, communication difficulties, lack of knowledge about how to access resources, and lack of well-defined processes by which the communities could learn from experience. Lessons learned about integrating community capacity building and a healthy communities initiative are discussed. (TD)

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A Healthy Communities Initiative In Rural Alberta: Building Rural Capacity For Health

Kathy GermAnn, Neale Smith, Lori Baugh Littlejohns, Canada

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A Healthy Communities Initiative In Rural Alberta: Building Rural Capacity For Health

Kathy GermAnn, Neale Smith, Lori Baugh Littlejohns, Canada

Abstract

The David Thompson Health Region (DTHR), situated in central Alberta, serves 190,000 people, two thirds of whom live in rural areas. In this paper, we describe how the DTHR has brought the principles of the healthy cities/healthy communities movement together with practical strategies for assessing and building capacity in four rural communities. Key lessons learned from integrating community capacity assessment/building with a healthy communities initiative are: i.) the capacity assessment process appears to be effective in raising awareness, stimulating dialogue, and fostering learning about the community's ability to work effectively together to improve health; ii.) discussion about community capacity must begin early in the healthy communities process; iii.) community capacity assessment appears to be most useful and effective when communities are planning actions to improve health and well-being; iv.) the importance of following capacity assessment with actions to build capacity cannot be underestimated; and, v) we as facilitators of a capacity building initiative need to continue to build our repertoire of capacity building knowledge and skills. The paper concludes with suggested directions for future research and opportunities for collaborative research in rural communities.

Health professionals are today more aware than ever that the challenge of creating and sustaining healthy places -- settings in which all people can achieve health and realize their potential -- can only be met with the collective and cooperative effort of community members. Efforts are shifting, then, away from programs meant to "deliver health" and toward projects and activities that build up the capacity of communities to work together at creating the conditions under which they can thrive and prosper. In this paper, we describe how one health authority in central Alberta, the David Thompson Health Region (DTHR) has brought the principles of the healthy cities/healthy communities movement together with practical strategies for assessing and building the capacity of our communities.

We want in particular to focus upon how our Healthy Communities Initiative (HCI) has been implemented in four rural communities. This is in part because ours is a largely rural region: of our current 190,000 residents, approximately 60,000 live in the city of Red Deer and the remaining two thirds live in what we consider to be rural areas. (This is not a description based on the Statistics Canada definition of urban, which is any place of more than 1,000 population, but one which reflects our experience that villages, towns and rural areas have a way of life that distinguishes them from centres whose population is 20-, 30-, 50,000 or more.) Our focus upon rural communities is, however, also driven by a sense that the healthy communities approach may take on a different form and meaning in this setting.

After all, when the World Health Organization's Healthy Cities concept was first brought to Canada as an organized process, it took the name healthy communities because, as Manson-Singer (1994) relates, "In Canada, there are many communities and relatively few major cities. Renaming the project ensured a broader base of participation and a uniquely Canadian approach to the Healthy Cities movement, because all sizes of community were welcome" (p. 108). The term healthy communities has been adopted as well for several American examples, including California, Indiana and the Colorado Healthy Communities Initiative (CHCI), on which the DTHR's process was modeled. Conner et al (1998) argue that "the high percentage (64 percent) of rural and frontier communities involved in CHCI is unique for a healthy communities program.... Due to this important difference, CHCI provides the opportunity to learn special lessons about the development and outcomes of healthy communities projects among rural and frontier communities" (p. 22). Without joining the chorus of those who claim uniqueness, we hope in our own way to contribute to a better understanding of how the health of rural communities can be advanced and strengthened.

The Healthy Communities Initiative in the David Thompson Health Region

In April, 1998, the David Thompson Health Region (DTHR) launched a Healthy Communities Initiative (HCI) in five communities, one urban and four rural. As noted above, the HCI process which we have used is based upon that of the Colorado Healthy Communities Initiative (CHCI). The CHCI process, unlike many healthy community models, is well defined and has been extensively evaluated since its inception (Conner et al, 1999). In essence, the process involves (a) the creation of a widely shared vision of a healthier community; (b) an assessment of current realities and trends including both community needs and capacities; (c) the selection of key priority areas for action; (d) the creation and implementation of action plans; and, (e) evaluation and monitoring of actions through the development of community-level indicators to help assess progress toward the vision. Communities are free to revise and adapt the process according to their unique character and needs.

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The following are core principles that guide the DTHR's healthy communities work. First, it is based on a broad definition of health; not the traditional biomedical conceptualization of health as merely the absence of disease but a wider perspective which acknowledges the critical contribution that income, employment, education, social support networks, healthy child development, the physical environment and gender make to health. Second, the essence of the HCI is building upon existing community resources and capacities, rather than adopting a "needs" approach that emphasizes deficits and problems. Third, the HCI aims to achieve community ownership through broad public participation. This ensures that the process leads to priorities and actions that have been identified by the community as a whole, rather than by select interest groups. Fourth, the impetus for collective action in the HCI is seen to be a shared vision throughout the community of a healthier future. The perspective is long term, rather than "quick fix". Fifth, because the HCI focuses on the broad determinants of health and because it aims to get communities working together as a whole, collaboration between multiple groups and sectors is crucial. Such collaboration allows initiatives to be linked, resources pooled, and duplication avoided. Ultimately, this requires change at the systems/sector level so that policies which support partnerships and collaboration can be developed and implemented.

These activities and principles would seem in many ways to fit well with the nature of rural and small town life. Rural communities, for instance, are generally more homogeneous than urban ones, and therefore ought to find it easier to arrive at a commonly shared vision. Residents in rural communities, as well, are described "as being more self-reliant than urban people.... more apt to use family, friends and local groups (e.g. church groups) for support" (Alberta Heart Health Project, 1999, p.17). Thus, rural areas ought to understand and approve of a capacity building approach. Finally, rural areas normally do not have the same agency and service delivery structure that exists in urban areas, and thus continue to demand greater public and volunteer involvement. As we shall show in this paper, our experience in the HCI both supports and belies many of the traditional assumptions about the nature of rural life.

The core of the HCI is community capacity building. We define community capacity as "the ability of people and communities to do the work needed in order to address the determinants of health for those people in that place" (Bopp et al, 2000).[1] We have identified and defined seven domains of community capacity: shared vision, leadership, sense of community, participation, resources/knowledge and skills, communication, and ongoing learning. (See appendix for complete definitions of each domain). The community is able to modify the domain definitions or create new domains if they wish.

The community capacity assessment process used in the HCI is highly participatory in nature. A formal, public meeting is held. For each capacity domain, the definition is reviewed and all participants are given an opportunity to rank the community in terms of how well developed that particular capacity is. Each person then is able to share his or her ranking and reasons for the ranking. Participants are encouraged to reach consensus on one numerical ranking for each domain. This process fosters discussion and mutual understanding. The end result is a rich and engaging dialogue about community dynamics. Verbatim comments are recorded, as are numerical rankings. The data is subsequently analysed by a small group of community members and outside experts. A detailed report, complete with recommendations for enhancing community capacity is written and presented to a core group of community members who then plan and implement actions aimed at building community capacity.

Integration of community capacity assessment and capacity building with the healthy communities process was envisioned to help communities identify existing strengths that could be applied in implementing actions, as well as to strengthen any identified weaknesses prior to, or in conjunction with action planning. In reality, each community used its capacity assessment findings in various ways which we describe later in this paper.

The HCI Communities

Of the five communities selected to participate in the HCI, four communities are situated in rural areas. Two communities, the towns of Sylvan Lake and Lacombe, are of moderate size – between 5000 and 8000 population; both are experiencing rapid growth. The remaining two rural communities, the villages of Elnora and Caroline, are much smaller in size, with populations of only a few hundred. While each community is unique, we trust that their common experience with the HCI will enable us to draw conclusions about how the process works in rural areas and about the kinds of challenges and opportunities facing rural Albertans at the beginning of the twenty-first century.

Caroline: Caroline is a scenic community located within view of the mountains, about one hour southwest of Red Deer. Population of the village is 472 with a surrounding population of approximately 2500. A capacity assessment revealed Caroline to be a community with many strong qualities but also many

[1] The HCI and a grant from Health Canada's Population Health Fund enabled the DTHR to work with the Four Worlds Centre for Development Learning to further our understanding of community capacity assessment/building. The details of the capacity assessment process that arose from our work with the communities are presented elsewhere (see Bopp et al, 2000) and the reader is encouraged to contact the authors of this paper for more information

challenges in working together effectively. In this small town, for example, there are over forty community groups, often with overlapping goals. Key priority areas for action selected by 34 community members at a community breakfast event were: "children and youth"; "education and lifelong learning"; "individual health care and support services", and the "clean, natural beauty of our community". Progress has been slow with most emphasis on working with youth who wish to explore "best practices" in developing and maintaining youth centres, with the goal of opening such a centre in Caroline.

Elnora: Elnora is situated 45 minutes southeast of Red Deer. The town itself has a population of 250 but when the surrounding areas are included, the population reaches approximately 1600. The average age of the town population, at 42 years, is above that of the province as a whole and the proportion of seniors living in the village (26%) is more than double that of the health region as a whole (11%). With this elderly population, and given the distance to Red Deer, there is understandable concern about the accessibility of health care services and the current lack of long term care beds. Having lived their entire lives in this community, the elderly fear the prospect of being removed from their familiar and supportive environments should they require institutional care. To make matters worse, Elnora's 10 bed hospital was closed in the mid-1990s as part of the DTHR's efforts to rationalize the delivery of health care services. Not only did this remove the comfort of having a health care facility within the community, but also it weakened the town's economic base, leaving several people unemployed. Furthermore, the hospital was symbolic of the community's ability to work well together, as much volunteer labor and fund raising was involved in building the hospital.

Currently, three key priority areas for action are being addressed in Elnora: primary health care, effective communication, and enhanced programs for youth. The primary health care initiative has centered on the employment of a nurse-practitioner as well as injury prevention and first aid training projects. Effective communication is being addressed through the establishment of a community "newsroom" where information can be coordinated and exchanged. Youth in the community are striving to enhance recreational opportunities by finding a gathering place and seeking support for the construction of a hard-surfaced ball court.

Lacombe: Lacombe is a community of 8,000 situated 30 km north of Red Deer. Lacombe's interest in the HCI was captured by the process's emphasis on community visioning, an activity the applicants had already been considering for the community. In addition, the value of facilitation provided by the DTHR was deemed by Lacombe to be important. Although Lacombe chose not to undertake a formal capacity assessment, there is ample evidence of the community's ability to work together effectively. The community has a strong volunteer, church and community group base with numerous links between these and agencies and businesses.
Three priority action areas have been selected: (a) "preserve, expand, and enhance Lacombe's natural areas, green spaces, parks and (hiking/biking) trails"; (b) "increase access to all levels of care and service for seniors to ensure our aging citizens will not be forced to leave Lacombe"; and, (c) "provide for the social needs of Lacombe's teenage youth with for example, an accessible movie theatre and/or drop-in centre where they can hang out in a safe and friendly environment".

The natural areas group has focused on the preservation of natural areas within the town itself. The seniors action group began by reviewing available resources for seniors within Lacombe. Upon realizing many resources already exist, the group decided to focus on something tangible and relatively easy to start with – transportation for seniors. Again, it was discovered that there are many available resources for transportation. The issue of access to health services, then, has proven not to be as pressing an issue within the community as was initially presumed.

The youth action group has worked busily to find ways to address their social needs, which appear to be related to having opportunities for recreation through a safe, friendly place to meet, socialize and have fun. After much reflection they decided that the most important "first step" would be to have a youth coordinator who could work with them to organize activities and events. They have also formed a youth council. Throughout the process, youth have been in control, supported by adult mentors.

Sylvan Lake: Sylvan Lake is one of the fastest growing communities within the DTHR. It is a popular resort area as well as being within easy commuting distance (25 km) of Red Deer. The permanent population is approximately 5,100, but this can be several times greater during the summer. Tensions are brewing as the construction of new residential, commercial and industrial sites escalates while long-time residents and newcomers who have migrated from Red Deer and other centres to enjoy the small town atmosphere seek to maintain the status quo. Concerns about potential harm to the community's ecosystem are being raised. Increasing tourism brings many unique challenges in terms of space, safety, service provision and crime prevention. Some residents feel the community is spending too much energy focusing on tourism and not enough caring for the year-round residents. In a capacity assessment, several participants said they feel powerless against the developers who seem to forge ahead with new construction despite the wishes of everyday community members.

Sylvan Lake's vision statement focuses on five key elements of community life: natural beauty, people connecting, living together, balanced development and healthy liv. Currently, action groups are working on natural beauty, looking at both short-term (e.g.

"Communities in Bloom" competition and a clean-up campaign) as well as long-term (maintaining a healthy environment and preserving natural areas) activities. Another action group is looking at "people connecting", in particular, working with the family and children's services authority to create a Neighborhood Place – a "one-stop shopping" facility which people can access to find out about available resources.

Health Issues in the Four Communities

Four health-related issues have emerged consistently among the four rural HCI communities.

First, youth development is a priority issue. Several sub-issues have been identified by the youth: (a) a perceived lack of social and recreational opportunities; (b) a desire among youth for a safe and friendly place to "hang out" in order to have fun and keep out of trouble; (c) a sense of not belonging to the community and a desire to have greater involvement in community life and community decision-making; and, (d) a perception that youth are viewed by adults as "bad". In a workshop to identify priority issues with teens from the four communities, issues of self-esteem, communication and leadership were selected as priorities. In addition, capacity assessments revealed the need for adult and youth leadership development. Our early lessons learned in working with youth is that they highly value the support and mentorship of adults who are committed to allowing youth to drive the process. Furthermore we have learned that when youth are ready to tackle an issue, it is crucial to act immediately so the momentum is not lost. The continued viability of smaller communities depends in many ways on their ability to retain young people. Making the community more attractive to youth, and giving them opportunities for leadership and decision-making should contribute to stronger connections and less desire on the part of youth to leave the community.

A second theme emerging from the participating communities is a concern with natural beauty and preservation of the natural environment. Citizens take great pride in the natural environment and display a strong desire to maintain its beauty and integrity despite threats imposed by economic development. Since proximity to nature is one of the major reasons why people move to or remain in rural areas, there is great value in maintaining and building upon these assets.

A third theme focuses on maintaining a strong sense of community in the face of changing social dynamics. All communities in the HCI are experiencing change in their social structure. In the small villages of Elnora and Caroline, long-time residents have lamented that there is not as strong a sense of community as in the past. Out migration of youth and young adults in search of education and employment, and in-migration of retiring farmers and young families who are seeking a small town atmosphere, but who bring new and sometimes conflicting values are forcing changes in the status quo way of doing things. This is intensified in the towns of Lacombe and Sylvan Lake, which are within easy commuting distance of the city of Red Deer and can serve as "bedroom communities."

A fourth consistent theme has been access to health services, particularly in regard to seniors and access to continuing care beds. A shortage of these beds (and of funding from the provincial government) means that people requiring institutional care have been displaced from their communities and their social support networks. A recent infusion of funding from the government is supposed to help alleviate this problem. Access to other health services, particularly in the smaller villages of Elnora and Caroline is also limited. These small centres lack the services of health professionals such as physicians, and mental health workers. Transportation to larger centres for access to these services is therefore an problem for those who do not drive or own their own vehicles.

These issues are clearly not unique to rural communities. Concerns about youth, about preserving natural areas, about declining sense of community, and about access to health and other services are raised in urban areas as well, including the HCI's one urban neighbourhood. Nonetheless, in rural areas these concerns take on particular forms. Some of the issues that we might have expected to emerge in rural communities have not surfaced in the HCI to date -- for instance, the "farm crisis". This may in part be due to the fact that central Alberta has traditionally been a relatively prosperous area for agriculture. It may also reflect that the HCI process has not engaged farm-dwellers or others outside of the towns and villages themselves, despite an expressed intent on the part of all four communities to do so. Participants in the process themselves have stated that this group has not been as well represented in the HCI as would be desirable (David Thompson Health Region, 1999).

Capacity Building Issues in the Four Communities

The philosophy of community capacity building is that whatever issue is deemed most important to act upon, certain capacities are required. Community capacity is akin to the gasoline that powers a car to reach the driver's destination. Before embarking on a journey, the driver inevitably checks the fuel level and if it is low, gets a fill at the local gas station. Similarly, communities wishing to take action on their priority issues need to do their own "check up" to see if they have the fuel it will take to reach their destination. In other words, they need to assess their capacity to work together to address the priority issue. Whether communities choose to work on youth development, preservation of natural spaces, maintaining a strong sense of community, increasing access to health care services, or any other issue, they inevitably require a basic level of capacity to work together to achieve their goals.

In the HCI, we undertook formal capacity assessments in three of the four rural communities discussed here, in each identifying several areas where capacity could be strengthened. While each assessment revealed findings unique to the community there were consistent findings as well, which may be generalizable to other rural communities. These are described below.

Shared vision
Broad community ownership of a vision for a healthier future has generally not been achieved. In order for collective action to occur, more work needs to be done to ensure the vision is shared throughout the community.

Participation was consistently identified as an area in which communities wanted to do better. It was acknowledged that often a small core of people are doing "the work" of the community. However, there appears to be a lack of knowledge and skills regarding how to gain broader participation, particularly from 'hard-to-reach' groups.

Leadership
Consistent to all assessments regarding leadership was the need for further development of facilitative and participatory (vs. "top-down") leadership in both adults and youth. Dynamics of power and control were also raised in the three assessments. In each community, there appear to be people who are particularly powerful and have great control over many aspects of community life. This leaves other community members feeling powerless and consequently unwilling to participate in community affairs.

Sense of community
It was revealed that within each community there are sub-communities, each experiencing the community in a different way. All three communities identified the fact that there are groups who are "in" and those who are "out". In every instance there were people who said their community was the best place in the world to live, and those who said they felt estranged and excluded from community life.

Communication
In all communities, people identified challenges in ensuring that information was fully communicated. It was acknowledged that use of a variety of channels is important. Some people do not read, others cannot hear. Consistently, it was identified that people need to take the time to really listen to what other people are saying.

Resources, knowledge and skills.
People at every capacity meeting were easily able to identify the wealth of resources, knowledge and skills residing within their community. The only challenge is in knowing how and where to access these resources.

Ongoing learning
In terms of ongoing learning, responses were varied. It is apparent that while individual groups within a community may have well defined processes for learning from their experience, the communities as a whole do not.

Lessons Learned in Assessing and Building Community Capacity
Our findings about community capacity both support and contradict what stereotypes about rural life might suggest. Contrary to the idea that rural communities are homogeneous, the capacity reports clearly show that in each case there are sub-populations or groups that do not fit in with the dominant ethos of community life. And while there may perhaps be generally shared agreement about the ideals expressed by the community vision statement, even in these small towns it has proven challenging to achieve widespread knowledge of the vision and commitment to it as a guide for action. There are also challenges in achieving effective communication despite -- or perhaps because of -- the fact that word-of-mouth can reach a significant portion of community members. On the other hand, it was clear that all the communities possessed abundant skills and resources, and as well were quite able to obtain support and finances from outside sources.

Each participating community has used the findings from its capacity assessment in various ways. One community has acted upon several recommendations, including asset mapping to identify and locate existing resources, knowledge and skills, and working with the local child and family services authority to develop a one-stop shopping facility through which community events and activities can be communicated, and people can be connected to the resources they need. In this case, the anticipated effect of using capacity assessment findings to build capacity in order to take effective action was achieved. Another community used its capacity assessment findings to build its vision statement, but have not yet taken any actions toward addressing identified weaknesses. The third community has not fully taken advantage of the findings at this point, although the report has generated considerable discussion about how the community currently works together. All participating communities, however, have found the capacity assessment process very helpful in understanding community dynamics more clearly.

From our experience in integrating community capacity assessment and building with the healthy communities process we have learned the following. First, the capacity assessment process appears to be effective in raising awareness, stimulating dialogue, and fostering learning about the community's ability to work effectively together to improve health. Second, discussion about community capacity must begin early in the healthy communities process. This helps emphasize that the desired outcome of the process is enhanced community capacity to work together as a whole and helps the community differentiate the HCI process from other seemingly similar grant initiatives. Third, timing is everything. Community capacity

assessment appears to be most useful and effective when communities are planning concrete actions to improve health and well-being. That is, "capacity for working together on youth development" is more meaningful than the somewhat abstract notion of capacity to work together in general. On the other hand, we believe there are times when it would be valuable to assess one or two of the domains – at the beginning of a community planning process, for example, in order to assess the kind of leadership that exists and the extent to which people generally participate in community events. We have learned the importance of being flexible enough to capitalize on "teachable moments" and discuss specific domains when appropriate opportunities arise. Fourth, the importance of following capacity assessment with actions to build capacity cannot be underestimated. Unless the findings of the capacity assessment are integrated into action, the entire exercise appears to be academic and interesting but not highly useful. Finally, as facilitators of a capacity building process, we must continue to expand our own repertoire of knowledge and skills for building community capacity in each of the seven domains.

Conclusion

In this paper we have presented an overview of our efforts to integrate a practical approach to community capacity assessment/capacity building within a healthy communities initiative in four rural Alberta communities. These efforts have been moderately successful, however, more research is required to understand in greater depth how the processes can best be integrated in rural communities. An issue that would be interesting and fruitful to explore would be a comparative analysis among the four rural communities in our HCI, two of which are progressing well, and two of which appear to be struggling with the process. Illumination of facilitators and barriers (both within the communities, and within our own organization) to implementing the HCI process in these various communities would help inform rural development practice. In addition, research into the four health issues identified by our HCI communities could further help inform rural development practice. For example, research to identify best practices in rural youth development, as well as finding ways to slow the out-migration of young people to larger centres would be very valuable. Research partnerships with economic development, education, and rural sociology would be a good starting place.

Restrictions on space have precluded a full discussion of the successes and challenges of implementing the HCI process within our five participating communities. We have, however, spent considerable time evaluating the HCI (see Smith, 2000; David Thompson Health Region, 1999) and readers wishing to know more should contact the authors of this paper.

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Appendix

Community Capacity Domain Definitions[2]

Shared Vision
What is it?

A shared vision is a picture of the community at some time in the future, painted in enough detail that people can imagine it.

When the goal is to build a healthier community, a shared vision is not complete unless it:

- Is realistic enough that people believe it is possible to reach.
- Presents a tension between the desired future and the current situation. This tension inspires people to take action toward reaching the vision.
- Includes a statement about how people want to work with one another in order to achieve their goals, and about the values that need to be shared in order for people to work effectively together.

[2] Source: Bopp, GermAnn, Bopp, Baugh Littlejohns & Smith, 2000

- Is richly detailed and thereby points to a pathway (possible goals; principles and processes to be followed) for action and change.
- Is shared because it is created through true dialogue and consensus with people from all walks of life in the community.
- Is built upon individuals' needs, experiences, and aspirations - people feel they "own" it.
- Inspires and motivates community members to actively take part in making their community a healthier place to live.
- People interpret it and can tell others about it in a consistent manner.

Sense Of Community
What is it?

Sense of community refers to the quality of human relationships that make it possible for people to live together in a healthy and sustainable way.

When there is a strong sense of community:

There is a sense of place and history. People do things together and often share ways of doing things in common, such as decision-making, celebrating, or grieving, which helps give the community a shared identity.
Relationships among community people are built on trust, cooperation, shared values, togetherness, and a shared sense of commitment to, and responsibility for, improving the community.
There is a climate of encouragement and forgiveness, openness and welcoming.
Community members feel they are safe, that they have a voice, and that they can make a contribution to the community.
They also feel cared for, and in return, they care for others.